

# **Clinical Operations Workgroup Draft Transcript February 5, 2010**

## **Presentation**

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. Good afternoon, and welcome, everybody, to the HIT Standards Committee Clinical Operations Workgroup. The call is being conducted in public, and there will be an opportunity at the close of the meeting for the public to make comments. Let me just introduce or do a roll call of the members. Christopher Chute? Jamie Ferguson?

### **Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Present.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Martin Harris? Stan Huff? Kevin Hutchinson?

### **Kevin Hutchinson – Prematics, Inc. – CEO**

Present.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Liz Johnson? John Klimek? Don Bechtel? Joyce Sensmeier?

### **Joyce Sensmeier – HIMSS – VP of Informatics**

Present.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Wes Rishel? John Halamka?

### **John Halamka – Harvard Medical School – Chief Information Officer**

Present.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Eric Strom, DoD?

### **Eric Strom – DoD Military Health System – Program Management Support**

Yes.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Chris Brancato?

### **Chris Brancato – Deloitte – Manager, Health Information Technology**

Good afternoon.

### **Judy Sparrow – Office of the National Coordinator – Executive Director**

Did I leave anybody off? Okay. With that, I'll turn it over to Jamie Ferguson.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Thank you very much, Judy. As we had discussed previously, the purpose of this call is to discuss comments that we want to make from the clinical operations group to the full standards committee at the next meeting. And so what I'd like to do is perhaps first just open it broadly to anyone in the workgroup to talk about comments, and if we can go through and maybe if we can characterize different possible comments on the controlled vocabulary standards first, and then move to the content exchange standards, and then move to other certification functional criteria, comments that we might make. I think we can just kind of go through it in order like that, and I just wanted to say that I recognize that some of the things that have been noted in public and in other fora are things that I would call technical corrections versus substantive changes to the IFR that are being recommended. If folks can characterize, if there's an easy characterization of things that would go into sort of the technical corrections bucket, I think that would be helpful.

**John Halamka – Harvard Medical School – Chief Information Officer**

This is John Halamka. I'm happy to start with a general comment to try to seek the workgroup's advice. We know that the reason that ONC did not provide specific implementation guidance in the IFR was the concern that a regulation would ossify a standard. It would not be changeable. Therefore, as evolution occurred, as refinement to implementation guidance occurred, it would require a change of regulation in order to introduce such change. I completely understand and respect that.

The question, of course, is that HL-7 2.5.1 is mentioned multiple times, and HL-7 2.5.1 is a great standard. It is also a broad standard. And so, to suggest that every lab in the country simply have to use HL-7 2.5.1 however it wishes to implement runs a risk of creating a tower of babble of incompatible HL-7 2.5.1 implementations.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

If I could just jump in to amplify that particular point, John, I think that right now we're aware of probably in the neighborhood of 2,000 unique implementations of HL-7 version 2 that are being used by just the top few commercial labs for results messaging, so I think, exactly to that point, saying 2.5.1 alone could result in still 2,000 unique implementations of 2.5.1.

**John Halamka – Harvard Medical School – Chief Information Officer**

And so one wonders, should our comment be to the effect, we respect the nature of the IFR as a regulation, but urge ONC to issue a guidance letter separate from the regulation within the next 120 days, you know, based on input from the HIT Standards Committee, that is additional implementation guidance, constraints, reduction of optionality, etc., or something to this effect.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

And so that would apply broadly then to all the different mentions of 2.5.1, I take it, right?

**John Halamka – Harvard Medical School – Chief Information Officer**

Right. So there's 2.5.1 and 2.3.1. In fact, let's actually describe a problem there, Jamie, that you identified, which is the CDC for all of its public health lab reporting and immunizations reporting has an implementation guide for 2.3.1, but I don't believe has an implementation guide for 2.5.1. So here we have this challenge. Wait a minute. The CDC says you must use 2.3.1, but the IFR says you could use either. So it gets to this whole challenge of how do we insure there's enough specificity so that interoperability occurs while, at the same time, not creating ossification. And so, yes, the comment applies to immunizations, public health lab reporting, syndromic surveillance, and generally any place a lab is used.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

I think the suggestion there is that we would comment to urge ONC to issue guidance quickly with constraints in order to eliminate some of the optionality in the adopted standards.

**John Halamka – Harvard Medical School – Chief Information Officer**

That would be my recommendation.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Certainly, since we had previously recommended specific implementation guidance that obviously didn't make it into the IFR, is there any objection to that, or is that just something that should be an overriding concern of ours that we mention?

**John Halamka – Harvard Medical School – Chief Information Officer**

We must take silence to mean consent.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

I think so.

**M**

No objection.

**John Halamka – Harvard Medical School – Chief Information Officer**

Great.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, that's great. Now, you know, we talked about that in the context of the HL-7 2.5.1. Is there similar guidance that we think, I mean, does that general theme of requesting more specific implementation guidance in order to eliminate optionality, does that apply to the other standards? I had wanted to kind of go through the controlled vocabulary standards, but you could say that that same general theme would apply in multiple places to the controlled vocabularies, to the content exchange, those things being essentially within our scope, but also to potentially some of the privacy and security guidance as well.

**John Halamka – Harvard Medical School – Chief Information Officer**

Let me take that one on. I hear in the industry that C-32 as a constrained implementation guide of CCD has actually been extremely useful to many communities and implementers because it gives extraordinarily detailed specification as to how the CCD should be implemented. And so, recognizing that our goal here is to make sure the regulation, that's a direction, but yet the industry has enough guidance to create interoperability and connectivity. I think it generally applies to CCD, HL-7 2.5.1, and the vocabularies and code sets that we are to discuss because obviously we hope there are subsets, such as the SNOMED CT, CORE set, or specific crosswalks and maps that we could reference to provide guidance to the industry.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

John, this is Wes. I am a little confused. Are we working on sort of external guidance or comments on the IFR? The reason I ask is that I understand that the practical impact of commenting on the IFR is that they might leave something out, but they can't add anything.

**John Halamka – Harvard Medical School – Chief Information Officer**

Well, so let's actually reflect on that, which is that David Blumenthal, when I raised that exact question, said we want to get this right, and that any and all comments, including additions, are appreciated. Jamie, I don't know if you heard the same thing.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, I think the specific guidance that I think we heard at the last standards committee meeting with regard to making these comments was that in fact, Wes, you're exactly right. Overall, they can't add any provisions, or they're not likely. They can't add any provisions without going through a more expensive process, but that adding constraints or modifiers or removing things are all in the realm of possibility. And also, I think we heard that those kinds of constraints or modifiers that are logical extensions of the things that are described in the rule are things that are most welcome, and so I'm not sure. I mean, I think that if we're talking about a guidance letter, well, that's actually outside the rule itself, but I think making that as a comment on the rule to me still makes sense.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right, and so, I think, Wes, directionally you're correct. That is, they're not going to do some sort of wholesale revision. But if there was deletion, change, or a compelling justification for some additions that were a direct result of many comments made, then I think David would certainly consider that.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Now something else that I would add on this, I think we heard from Doug Fridsma's presentation at the standards committee was that if there's a standard that's adopted for one purpose, or anything that's mentioned even in the preamble could potentially be added for another purpose.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes. So C-32, having been mentioned in the preamble, as we decided not to do it, is now okay to do?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, that makes it within the realm of possibility to comment on for inclusion. Yes.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I think the most important thing is that we're encouraged to provide comments where there's extremely important and let them worry about the process and what the lawyers will decide can be done without another round of comments. I would agree that the lack of implementation guidance around the current choice of standards that are noted is a significant issue. I don't even think NIST can test against it. I mean, you know, how do you test against CDA or CCD?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

That may be a little more difficult. I think, for 2.5.1, their testing job, in my view, becomes remarkably easy because it's any 2.5.1.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right. And so I think, Wes, the question you would really ask is what is conformance versus what is interoperability because you can conform with 2.5.1 and still not be interoperable between versions or implementations of 2.5.1.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Or another way of saying it is that all conformance tests fall short of completely assuring interoperability, but the NIST ones, according to the current IFR, would fall way, way short.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Right, so one other question: The way I read the two regulations together, the NPRM and the IFR, products have to be certified against standards in the IFR, and eligible providers and hospitals have to do the interoperability required by one or two measures there, but there is no requirement that they do that interoperability using the standards.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

That's my interpretation as well.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Okay. Thanks.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Jamie, this is Kevin. I had a general comment and question that maybe you guys can help with because I've heard this at multiple various different public sessions, and most recently at the annual EHI meeting. A gentleman from Geisinger stood up and made this statement as well. And I don't think it's correct.

I don't know if it's a clarification or if in fact it's a comment we should be making as part of the rule about the fact that the reporting requirements, the quality reporting and any reporting requirements must be native in the EHR that they have if they have an enterprise type of EHR versus being able to meet the reporting requirements by dumping the data into a more sophisticated reporting engine of which they can then meet the reporting requirements. My initial reaction to that is, well, of course, we've allowed for modular EHRs, and as long as you're meeting the functionality, and especially these health systems that have deployed these systems in various ways. I don't believe that that's a correct statement that the reporting requirements have to be native inside of the EHR.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, I think they have to be native inside one EHR module at least, right? But I think, to your point, the data could be extracted and dumped into a warehouse or other kind of reporting system that is just the way you described it. And so I think you'd say that it has to be native within that, but that doesn't have to be within a complete EHR.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Yes. Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right, and so I would comment that we actually don't know the answer to this question yet because the NPRM on certification will be very clear about how certification processes are done. But from everything I have heard from ONC, it is absolutely fine to have an EHR that does gathering of the clinical data, replicates clinical data into a warehouse where an analytical tool run by a third party computes numerators and denominators, where then another third party sends such data to CMS. I mean, that's totally fine. I mean, it could be a byproduct.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Now I think there is—

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

First of all, yes, this is another example where the NPRM things that have to be done, the IFR says things that have to be certified. There's no logical connection that they have to be done in the manner that they were certified to be done. And, in addition, those two regs are pretty clear that what they are defining is this term called EHR technology as opposed to EHR, and EHR technology is the collection of all the things you use to solve the problems.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

I would think it's a bit premature to make a statement such as the EHR complete the one thing must do everything, but we'll find out when the NPRM is released in a month or two.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. I mean, I think it does raise a different issue that we may want to consider, and that is that the data extraction alone to meet those reporting requirements is a prodigious amount of work. And so that if it's not in a complete EHR, then doing it in this particular way could be problematic. Now there are some sort of technical, potential technical correction comments that we might want to make about the fact that, for example, there are 16 of the proposed measures in the NPRM have been retooled to use SNOMED only, but SNOMED in the IFR is not an adopted standard for those purposes. So that imposes a problem beyond the mechanics of the data extraction.

**John Halamka – Harvard Medical School – Chief Information Officer**

And, similar to that, all the work of NQF HITEP presupposed a CDA as a source of information. But yet, CCR and CCD are both allowed as mechanisms of patient summary transfers, so there's a disconnect.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes, so I wonder if there is, maybe there's a category of comments that we might want to consider making about these possible disconnects or what appear to us to be disconnects such as these ones related to the quality reporting. Does that make sense? One category of comments is about the lack of specific guidance, and we can talk about HL-7 version 2 and CCD and vocabularies and potentially other things there. But I wonder if another, if this might be just another broad category like that.

**John Halamka – Harvard Medical School – Chief Information Officer**

Sure. I mean, if implementation guidance is one, and two would be inconsistencies between various recommendations, I think it's very reasonable.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Now one of the things that certainly we spent a lot of time on in previous discussions that came out in the IFR was, as has been mentioned here, that both the CCD and the CCR are adopted standards and there's a hope for harmonization based on standards committee recommendations. Is there anything that we want to say about that in our IFR comments?

**John Halamka – Harvard Medical School – Chief Information Officer**

And so here's the interesting challenge, and you read the preamble, and it acknowledges that CCR has been implemented, in existent products and, therefore, to say it is not suitable would, in ways, I think, slow implementation adoption and innovation, so it recognize, use existing products, and allow CCR. Fine. But then how is the CCR repurposed for any of the population health mechanisms that we have worked on through HITSP or that are delineated in the NPRM, so certainly that's one comment. Then, two, recognizing that I think the CCR is fabulous for problems, meds, labs, and allergies. It just doesn't

have any capacity to send unstructured documents. The CCD is very good for doing unstructured documents and a number of the elements of the CCR, except it's XML. It's sometimes challenging to read and implement.

And so, hence, hard to know what the convergence is, but it could probably take two forms. Everyone I talk to at ASTM is interested in PDF for healthcare, which is going to be CCR plus unstructured documentation. And people at the HL-7 are interested in the green CDA, which is a skinned down, streamlined XML so that CCD now looks much more CCR-like, but also supports unstructured documentation. Now it may be a little bit premature to comment on this officially, but that's what I hear.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

The specific question of the suitability of CCR versus CDA for quality measures, and I talked to, gee, I'm forgetting his name now, but the guy that's done all this great work on the quality measures.

**John Halamka – Harvard Medical School – Chief Information Officer**

Floyd Eisenberg.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Floyd, right, yes, and he was just really concerned about this issue. I don't actually understand what you can code in the CCD that can't be coded the same way in the CCR. Is it specifics of what you can code or why is it he feels that way? Then, second, it's not clear to me that there are very many quality measures associated with stage one that rely on pulling data from outside the enterprise.

**John Halamka – Harvard Medical School – Chief Information Officer**

Let me take a stab at the first question, which is, I understand that the CCD includes significant metadata, time/date stamps, who was the actor, what was the event. So if you're looking at process measures, CCD is able to represent a process, whereas the CCR is really a snapshot of data at a point in time.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

No wonder one is more complex than the other.

**John Halamka – Harvard Medical School – Chief Information Officer**

Yes. So if you want to say this is my problem list, this is my medication list, this is my allergy list, and this is a lab result, CCR is fine. But if you want to say this test was ordered for this reason at this time/date, and then this result was achieved, and this interpretation was made, and this action was taken, the CCD can do that. The CCR cannot.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

So I would say that if that is in fact, there is a technical case to be made for why data collection through CCD better meets meaningful use requirements than data collection through CCR, and there will be some challenge communicating that because it's down in the weeds a little bit. It's a challenge appropriate for us to take on describing that and putting in a comment. I would, again, caution us to be sure that it – to identify how much of it is relevant to stage one versus potential future stages.

Jamie F  
Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

And I think the question really is what is the purpose of the CCR. If the purpose is to represent a summary of the patient's care for care coordination only, then the CCR is probably suitable. However, if it is to be used as input to quality measurements, then it is probably not.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes. I think that's the way we want to describe it. We don't want to necessarily take a stand on yes/no, but we want to compare the document to the various usages that would be put in the process of complying with meaningful use.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right. Now let me – I think this is a good issue, and I think, Wes, you've done a great job of framing it as neutrally as possible, let's say. I want to bring up a different issue, I think, with regard to the adoption of the CDA standard that CCD uses, which is that level two CDA, I believe, is the adopted standard, which does not require structured data sections, only narrative. And so, when you use coded terminologies, does that mean you have to put the codes in the narrative section, or do you have to include the optional structured data sections where the codes are specified? Maybe this is something that could be handled through guidance. But, I mean, for example, in the previous CMS NPRM for the claims data, claims attachments, they allowed level two and level three.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I think I understood every word, and I had a hard time putting it together as a sequence.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, so I guess the thing is, so if you use a level two CDA where no structured data is required, then I guess it comes back to the usefulness for interoperability purposes. If you put the coded entries in the narrative section, then you have to basically pull those out of free text.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

So I'm....

**John Halamka – Harvard Medical School – Chief Information Officer**

...my sense is, and this is a very good point--I actually had never noticed it--was that given that the CCD, through the C-32 implementation guide, has specific problem med, allergy, lab sections that the controlled vocabularies were to be used in those specific tagged sections relative to those domains and not embedded in an unstructured document.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right. I believe that's a level-three document specification.

**John Halamka – Harvard Medical School – Chief Information Officer**

And so by level three, you mean--?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

That includes the structured data sections.

**John Halamka – Harvard Medical School – Chief Information Officer**

CDA level three.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

Versus CD – which the family, the family, the CDA family has gone under revisions.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right, so this is release two, and then it's level two versus level three.

**John Halamka – Harvard Medical School – Chief Information Officer**

I see. Okay. But my understanding, right, is that the directional intent here is to say CCD has the capacity to represent not only unstructured documents, but structured data, and in the structured data sections, these vocabularies should be used.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

But we should clarify that.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes. I think this is another example of the point about C-32 that CDA by itself or CCD, well, CDA – what did they say, CCD or CDA?

**John Halamka – Harvard Medical School – Chief Information Officer**

They say CCD.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

All right. CCD in itself still has a lot of room for interpretation, thus creating a challenge around interoperability. C-32 reduces that variability by several orders of magnitude.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. Okay. How about comments on the controlled vocabulary standards, if we can switch gears a little bit? John, you had mentioned earlier that some of the areas where we wanted to talk about the lack of specific guidance or actually to request specific guidance would be in terms of both the value sets and the subsets of the vocabularies.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Do you want to elaborate on that?

**John Halamka – Harvard Medical School – Chief Information Officer**

I will. On the problem list, for example, SNOMED, I think we all agree, is a very good direction, but SNOMED implemented how? There's the VA Kaiser subset. There's the NLM CORE subset of 7,000 terms. Everyone could come up with their own boutique subset. And so, certainly, I think it would be interesting to say the National Library of Medicine has agreed to maintain the 7,000 most commonly used

problem list terms in a SNOMED CT CORE subset with crosswalks to ICD-9 that's available today for free, and ICD-10, which will be available, as an example.

LOINC, you would probably want to say the same thing that we know that LOINC exists as a mechanism to order and receive lab results. But, ideally, one would want a lab compendium standardized for the top 98% of laboratory tests ordered that could be reused over and over again. And, therefore, every time a lab system is implemented, you didn't de novo need to build your own one-off compendium. You could download a universal, orderable compendium. Again, Clem McDonald, NLM, have such a thing, and HITSP helped with that.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

For this discussion, let me differentiate. This is based on our discussions in the vocabulary group, differentiate three different kinds of subsets. One is, I think, John, what you're talking about, the frequency distribution or the frequency based subsets that cover some percentage or some cutoff point of the most frequently used concepts, terms, or codes that are perhaps a good starting point for folks who have to use a particular coding system.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Another kind of subset that's also a convenience for implementers, so that's basically a frequency based convenience subset. Another kind of a subset that's another convenience for implementers is based on specialty. And so it can also be based on frequency, but it might be the 40 most common orders for ophthalmology, as an example. And so you can imagine a proliferation of those kinds of convenient subsets for different specialties, for different purposes, and so I think, rather than the broad, the frequency distribution of the entire vocabulary, this is the frequency distribution for a particular medical specialty is a different kind of subset.

Then the third kind of subset is a subset that's really a value set, which defines the entire universe of codes that are used for a particular purpose, which is usually and probably in this case applicable for the quality measures. So we'd want to say that the entire value set of SNOMED and LOINC and CPT and ICD and HCPCS and whatever else that needs to be used for these quality measures must be supported because that's the universe of codes that's required for submission of those measures. What I would like to make, I guess, a friendly amendment to John's suggestion is we should make a comment that all three of these kinds of things are needed, although they may have different priorities.

**John Halamka – Harvard Medical School – Chief Information Officer**

And completely fair. This really gets into the same realm of how detailed is the guidance that we provide versus the direction that is stated in the regulation.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right. But at the same time, you wouldn't want to limit. You wouldn't want to essentially require the core subset of SNOMED or the 98% most frequently used point tests because then what if you have a lab test that's not in that list or a problem that's not in that problem list? Then you need a way of going out to the complete vocabulary to meet your documentation needs.

**John Halamka – Harvard Medical School – Chief Information Officer**

Correct.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

And then you have actually a different comment that would potentially, and since this would be new functionality, probably would be for stage two, but it would potentially require EHR technology to have the ability for users to discover the right problem or lab test or other concept in the required vocabulary, aside from these starter sets and convenience sets.

**John Halamka – Harvard Medical School – Chief Information Officer**

Very reasonable.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I think that there are two sub-issues there. I think one is what is the interface vocabulary, which is, I think, for a lot of what we're talking about, it's really the thing that we're thinking is most challenging. And the interface vocabulary arguably should be constrained to a subset and then not otherwise specified or something like that. That is, effectively there is no requirement that a sender send anything outside of the interface vocabulary. But, more specifically, there's no requirement the receiver receive anything outside of it. If they do, they're allowed to map it to NOS, which is how they do it now. That's how they do lab interfaces now is they get this ... rule mapping, and then the others you have to look at the text to find out what the test was about.

Then when it comes to problem lists, as maintained in the system, I don't know that we need to make any constraints on that. I guess I'm talking out loud, but I guess the best question is, are we talking about the interface vocabulary meaning the computer-to-computer interface, or are we talking about the internal structure of the EHR?

**John Halamka – Harvard Medical School – Chief Information Officer**

This is actually a great question because, on the medication vocabulary, for example, many people are asking me. I just don't understand when it says RxNorm mapping to existing commercial products in 2011, and then RxNorm itself in 2013. Are you telling me that in 2013, I have to replace First Databank, MediSpan, Gold Standard, and Multum with RxNorm native to the EHR? Or are we just saying, I can keep whatever I want as long as, over the network, between my EHR and the next guy, everything is RxNorm based? It's confusing.

And so I think the suggestion here, and Jamie, please let me know what you think, is that you would like the clinician on the problem list to physically pick a SNOMED CT code so that you actually have the granularity of SNOMED CT being used for that purpose. In the lab, you really want LOINC codes to be used in the result and, in 2013, on the order so that there's not mapping and ambiguity. But on medications, I think it's okay to maintain NDC or other mappable term in the EHR, as long as all data submitted for quality or e-prescribing outside the EHR is RxNorm directly mappable.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

The way they've designed it in the rule currently is that they've specified any of the vocabularies that are already completely within RxNorm. And so there's a zero gap, essentially.

**John Halamka – Harvard Medical School – Chief Information Officer**

However, there are some folks who have sent me interesting e-mails that FDB does not send its entire database to RxNorm, nor does MediSpan. Interestingly, and depending on how you interpret that statement, FDB and MediSpan wouldn't qualify as items, as databases that have their entire data inside RxNorm.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

My understanding is, they do qualify.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

I think that what happens, and perhaps it may be the point of discrepancy is that there's still a fair amount of local compounding of medications, and where a hospital or other provider does their own compounding, there's not going to be a premade FDB code for that that's part of RxNorm, but FDB may provide, or other drug knowledge providers may provide a way of dealing with those kinds of compounding issues. There may be other issues, but I know compounding is, I think, fits that exact situation.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

There's also going to be an issue of time lag, right? Things are going to get into FDB sooner than they get into RxNorm.

**John Halamka – Harvard Medical School – Chief Information Officer**

Interesting issue. What if a brand new drug is introduced tomorrow? Will the folks at NLM agree to incorporate brand new drugs as rapidly as might commercial products, and how do you deal with such gaps?

**Kevin Hutchinson – Prematics, Inc. – CEO**

Including brand and generics.

**John Halamka – Harvard Medical School – Chief Information Officer**

Yes.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right. Well, let's take the synchronization of updates issue in just a minute, but I want to get back, I think, the first issue that John raised, which is really to request clarification on what's in the EHR versus what's in interoperability, the same thing that Wes was asking, in terms of the vocabularies. I think John's suggestion was that for problems and labs, the adopted vocabulary must be used in the EHR, is what we would recommend, but that for medications, the adopted vocabulary must only be in interoperability.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I'm going to push back a little bit on that. I think that I have a more ideal formulation, although when you get down to pragmatics, we may end up back where John is. But I think of – well, John, you've got your own BID list, right?

**John Halamka – Harvard Medical School – Chief Information Officer**

Correct.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

What I heard is you were going to map that on the output. That you weren't going to change your system to select that in the user interface.

**John Halamka – Harvard Medical School – Chief Information Officer**

Here's what we did. Just by happenstance, Beth Israel Deaconess contributed its entire internal vocabulary to the Medi Thesaurus in 1998. And so we already, just like RxNorm, are native to the Medi Thesaurus. Therefore, we asked the folks at NLM to create for us a perfect map of the Beth Israel Deaconess proprietary problem list terms to SNOMED CT. We got that download six months ago, and then immediately changed all our HIE activities, including Google Health and Microsoft HealthVault, to emit SNOMED CT in a one-to-one mapping from our proprietary vocabulary. And, at the same time, I initiated a project to replace our proprietary vocabulary with SNOMED CT and a problem list picker that wouldn't use our existent proprietary vocabulary. That'll launch. It'll be done in another couple months, so it was just a timing issue.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Again, are we going to hold the country to your standards? A couple questions: Well, I guess we don't want to go to the update issue, but again I have the same issue. If you've got a lot of research going on, are you going to end up being ahead of SNOMED? Short of that, is there some formulation where we say that, in effect, you have to be using a vocabulary for problems that has a perfect map to SNOMED CT rather than saying you have to use SNOMED CT?

**John Halamka – Harvard Medical School – Chief Information Officer**

I think it's an interesting question, which is, if just like medications, you were able to achieve a good map in 2011, so that every problem that you exchanged with another entity was in SNOMED CT, but you're using whatever vocabulary inside your EHR, and then directionally, 2013, really try to get SNOMED CT into your EHR. Certainly, in talking to vendors, I hear from our EHR vendors, they believe that SNOMED CT, as a native internal vocabulary, makes sense, but maybe just again a timing issue.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. I was actually just going to go to the timing question because it sounds like there's not necessarily disagreement on the end state that John talked about in terms of what's required in the EHR for vocabulary versus what's required in interoperability. But there may be a timing issue of 2011 versus 2013 versus 2015.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I'm going to try to disagree here just because I wouldn't feel right if I agreed with everything, but I think an important issue around LOINC, around a practicality of rolling LOINC out is that the most frequent LOINC codes represent a significant subset of the total number of codes. Therefore, the mapping exercise that has to be gone through to take a system that's not using LOINC internally and have it interoperate using LOINC is much simpler. I have always seen that as an important benefit to having the subset. I certainly don't want to us to say, well, you have to do all of LOINC, even though you only have to have the subset or something like that. What I'm struggling with here is when we do we really need the full granularity of the code set? And when do we honestly only need a subset, except for purposes of research or something like that?

**John Halamka – Harvard Medical School – Chief Information Officer**

Let me give you an example. This is not coming from LOINC, and it's not coming from SNOMED. It's coming from medications. Partners Healthcare, which is a \$7 billion organization in Massachusetts, invented its own medication ... 20 years ago. It has hundreds of proprietary applications all running this completely custom medication set, which by the way could be mapped to RxNorm. It is not contributed to

RxNorm, but it could easily be mapped. Therefore, all e-prescriptions and all HIE activities could be RxNorm compliant. But to retool the internals of every partner's healthcare application to use either one of these contributed commercial products or RxNorm would be a substantial effort.

For Partners Healthcare, how do you solve that problem? Allow mapping forever? Encourage movement to RxNorm, but allow the timeline to be extended? This is an interesting general issue. I think we all agree that at the border of your organization, LOINC, RxNorm, SNOMED. I don't think that's really so much a question. It's then what we do internally and when.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Well, I think, in that general principle, we agree about the border, at least for LOINC, I argue for a subset of LOINC. And not necessarily saying that's just a temporary provision for 2011.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Let me just reiterate. What we've been talking about thus far is subsets as a convenience for implementers. We have not been talking about subsets really as a mandate, which, I think, Wes, is what you're bringing up. We've talked about the mandate. At least up to this point, we've talked about a mandate for the coding systems to be only the value sets that are absolutely required for the quality reporting. I think, essentially, if I understand correctly, you're expanding that to say that we would have one of these frequency distribution subsets that we would also recommend be a mandatory minimum for interoperability.

**Kevin Hutchinson – Prematics, Inc. – CEO**

I think, when we start thinking about timelines, and we have to think about what the goals are, and there are probably two questions that have to be answered. Is the goal in the short term to get every provider of care using the same medical/medication terminology, or is the goal in the short term to be able to facilitate the ability to exchange information across providers for continuity of care. I think the long term, and we'd probably have to ask the same questions for the long term. Is our long-term goal to get to a standardized medical terminology/medication terminology for all providers of care? I don't know the answer to that. I think the common person might say yes, of course. All providers should be using standardized terminology. But I'm sure that the providers of care have a variety of different views and opinions on why that may be a good thing and may be a bad thing.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. Let me just comment on one thing that I read in the NPRM and the IFR is that the section heading description, if you will, for stage one is capturing data in a coded format, so that implies that consistency in the EHR. Then, for stage two, it's really moving to, in addition to the quality metrics, it's talking about the exchange. That's where it's talking about the exchange in as structured a format as possible. I think, as a partial answer, Kevin, to your question, on what the short-term objective, what we've seen in the published rules is that the short-term objective is really about capturing coded entries.

**John Halamka – Harvard Medical School – Chief Information Officer**

Of course, the question then means coded in the case of my Beth Israel Deaconess problem list vocabulary is perfectly coded. It's just not in a standard coded format. And so, is it good enough to say it's not free text. It's absolutely structured and, therefore, mappable, or is it to the question that Wes asked?

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Well, I think the practical issue there is that we know, as a practical matter, that if it's not captured, it's something as complex as diagnosis, and it's not captured in the same vocabulary, there are going to be edge conditions in the mapping.

**John Halamka – Harvard Medical School – Chief Information Officer**

That's true.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Unless you in fact created the standard vocabulary, plus or minus the code that is represented by your input.

**John Halamka – Harvard Medical School – Chief Information Officer**

Right.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

So we are talking about the difference between a theoretical and a practical consideration here of the accuracy of interoperability. The accuracy will be more compliant if the data is captured in the right code set initially.

**John Halamka – Harvard Medical School – Chief Information Officer**

That's true. Let me give you an example of NDC. We all know that we end up with one to many mappings for NDC, and so I want to prescribe acetaminophen, the chemical, not the purple bottle with the 20% off coupon that holds 200 tablets. So when we do e-prescribing, we translate the FDB code to a representative NDC, which goes out to the pharmacy, and they fill because doctors don't think in lot numbers or package sizes. They think in chemicals.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Right.

**John Halamka – Harvard Medical School – Chief Information Officer**

We absolutely, therefore, falsify the map to pick some random NDC code that's acetaminophen.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Right. But, at that point, you've also created procedural rules for what a pharmacist is allowed to do, which you have anyways. I mean, they can go beyond picking it out of a different sized bottle.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. I want to agree with what Wes had said, but I want to do it perhaps a little differently. Earlier in this conversation, we talked about essentially a possible comment requesting that whatever the coding was internally within the EMR, it would have to be a perfect match, for example, to SNOMED for problems. I would submit that there's no such thing as a perfect match because all mapping is necessarily imprecise, and it's materially imprecise for clinical care. But that what we're really talking about in that case is essentially different display names.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Well, I think that, as a practical – it sounds like I just switched my side, in case nobody noticed. But I was meaning to point out a difficult tradeoff. I think that I find it, as a rule, pushing out standards to redo what you're always doing, what you're already doing, is almost never effective. The investment for the material, the return is not that high. There are limits on the material return that we offer through

meaningful use, and I would like to find a formulation that says that you have to be able to accurately create SNOMED on every output without actually saying you have to use SNOMED.

I realize the difference is a bit of sophistry there, but I wish there was some sort of – somebody ought to do the paper for Amy on defining good enough here. If 98% of the things that are entered in problems have exact representation in SNOMED, and if you go back the other way, you get back where you started, is that good enough? I don't know.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Where are you in the hierarchy, because if you go high enough up in the hierarchy, you're going to get to, for example, a disorder of deliver? And so it's something that you can map that perfectly to SNOMED. It's just that it's not at the level of granularity that you might want.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes, but that's why I was talking about it being reversible. I'm almost concerned that every concept you have can be represented at the same level of granularity in SNOMED, but if you don't have a few concepts, that's okay. I'm probably just being too – I'm trying to be idealistically pragmatic, and you can never have those two at the same time.

**John Halamka – Harvard Medical School – Chief Information Officer**

I've got to, unfortunately, jump off to another call, but let me just summarize by saying I think we agreed on a comment that says we certainly understand the use of controlled vocabularies between the EHR at the border and other users of the data. What is the directional intent ONC envisions for the incorporation of these vocabularies and code sets natively into the EHR? Depending upon that directional intent, we may want to make recommendations as to what the timeline might be and what is the eventual requirement for replacing mappings with native vocabularies. It could be different depending on the domain, medications, problems, and labs.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

I like that. Let me read it back the way I heard it was that, and this would essentially fall under our umbrella comment of needing more specific guidance. We would say we want specific guidance that would require some minimal use of LOINC, RxNorm, and SNOMED at the borders for interoperability, and we're requesting clarification on the intent of the use of these in the EHR.

**John Halamka – Harvard Medical School – Chief Information Officer**

Correct, because once we understand that intent, would could then, based on the debate we've had where I think some folks have said, you know, LOINC subsets as the native code, perfectly sensible. Medications, maybe if they're mappable, it's okay. SNOMED, I could go either way. I do like the idea of SNOMED native because I fear that in the mapping, you're going to lose granularity. You may do something like, I'm using ICD-9 and, therefore, I pick a representative SNOMED code, which is going to be not probably very good. It works for a representative NDC. It doesn't really describe the patient's problem very well.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Does that work for everybody?

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

Yes. John, that was masterful.

**John Halamka – Harvard Medical School – Chief Information Officer**

Thank you. Well, Jamie, I wish you a great weekend. I'm going to go jump off onto another call, and follow up by e-mail.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay, John. Thanks for your help.

**John Halamka – Harvard Medical School – Chief Information Officer**

Thank you.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. One of the other comments related to vocabularies that again was raised, I believe, in the last standards committee meeting of the full committee briefly that we might want to comment on is, it's really a stage two requirement, so it's something where there's no stage one adopted standard, but we still may want to comment at this point in time, and that is on the requirement to capture medication allergies only at the ingredient level. I think there's been a lot of discussion heard in the community about the fact that today medication allergies are generally captured primarily at the clinical drug level or the drug class. And sometimes if you know an allergy to a particular ingredient, you want that too. And so what I'm going to propose is that we put forward a comment requesting that not only ingredient allergies, but also clinical drug and drug class systems should be used, and UNII doesn't do all those things, but I believe RxNorm and UNII together might do that. Kevin, what do you think of that?

**Kevin Hutchinson – Prematics, Inc. – CEO**

Well, I was just sitting here thinking about that capability of the systems out there today and how they code that information today, and what would be required for them to be able to – because I want to make sure we're in parallel with the timeline of RxNorm being required. And it goes back to the discussion we just had, whether it's being required native within the application, or whether it's being required to be able to exchange.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. Let me bring up another thing, which is that nowhere in these things is NDFRT mentioned, but I believe a lot of folks who are coding entries for drug class right now are using NDFRT.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Right. Yes. Obviously, for patient care, I think it's the right thing to do. I'm just thinking about – I would have to consult with some folks smarter than me about the reasonableness of a timeline to be able to do that.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Well, again, so this is the current IFR doesn't adopt any standard for this purpose for stage one, but proposes for stage two, starting in 2013, that drug allergies would be coded only in UNII at the ingredient level, and I just don't see how that's workable for stage two.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Yes, I would agree.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Other comments that we want to talk about on this call? Let me bring up one. John Halamka, I think, mentioned this early at the beginning of the call. The IFR adopts both HL-7 2.3.1 and 2.5.1 for public health reportable labs. The current – if you go to the CDC Web site, as I did yesterday, you'll find they say that their 2.3.1 guidance is the most current version that should be used. And so I'm not sure if

there is a particular way of representing reportable labs in 2.5.1 that should be used or, indeed, if there's any public health agency that's capable of receiving that. I don't know of it. Is there a comment in there somewhere?

I'm going to propose that this goes into our list of things under the need for specific guidance. Would there be any objection to us recommending alignment with the CDC guidance in terms of the ONC guidance aligning with CDC?

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

I'm sorry, Jamie. I was called away for a minute. I came back in the middle of this. Can you give a two-sentence recap?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

The question is, the IFR adopts both HL-7 2.3.1 and 2.5.1 for reportable labs submission to public health agencies. I went to the CDC Web site yesterday and wanted to look up their most current guidance, which is their implementation guide for 2.3.1. I'm sorry. This is not for reportable labs. I'm confused. Thank you, Wes, for making me go over it because I caught my error. It's not for reportable labs at all. It's for immunizations and vaccination updates to immunization registries, querying immunization registries to get things like school reports and so forth. That is what 2.3.1 is used for according to the CDC, which says that's the most current version that should be used. Yet, the IFR also adopts 2.5.1 for that purpose. I don't know of any guidance for 2.5.1 for immunizations, nor of any agency that uses it. So I was going to recommend that we make a comment that for immunizations, updates, queries, and reports that the ONC guidance should align with CDC.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

As long as we know there's not other – I guess the question is, what about state immunization registries? Is it all CDC, or are there already states that are using 2.5?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

I don't know. I only know a subset of the states that are on 2.3.1 or 2.3.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Do we know the gap between those versions, because I know that, like in the NCPDP world, sometimes the gap between 8.1 and 10.6 or whatever the versions may be, sometimes is actually fairly minor, even though it sounds significant.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. And so the gap, I mean, it depends on what capabilities in the new standard are used in the implementation guide basically.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Yes.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

It could be no gap or a big gap.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Well, that would be my question is what level of effort are we talking about between those two versions? Is it significant, or are we just talking about a couple of additional data elements or changes in structure? I don't know the answer to that.

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

It sounds to me like we have a work item here, which is to determine what we want to do. Do we have time to somehow explore that? If so, how would we explore it?

**Kevin Hutchinson – Prematics, Inc. – CEO**

I do think in concept, though, Jamie, you're right in the sense that we should be aligned with what those requirements are, especially with CDC since it is going to be about public reporting.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes.

**Joyce Sensmeier – HIMSS – VP of Informatics**

Jamie, this is Joyce. I'm wondering if Floyd Eisenberg would be helpful or he could point us to the right folks to do that. If, like Wes said, we want to have a work item or just to make sure we're clear on what we're saying or asking for consideration. We want to make sure we know what we're requesting.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes. No, that makes perfect sense. I mean, Joyce, do you think that following up with Floyd is the right next step then?

**Joyce Sensmeier – HIMSS – VP of Informatics**

I think he could at least point us in the right direction. He was over the population health. I don't know that he's public health specifically, but I'm sure he could point us to the right folks.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Well, I will have some other follow-up items with Floyd, so I will take that one as well and get back to the group. It may be on our next call, or it may in fact be in the standards committee meeting that we hear back. I will take that work item. Other comments?

**Joyce Sensmeier – HIMSS – VP of Informatics**

One other thought I had, I don't have a specific example, but I wanted to see if the group wants to make any comments on timing of anything, stage one, stage two, etc.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Well, what would you recommend or what were you thinking of?

**Joyce Sensmeier – HIMSS – VP of Informatics**

I started my statement. I don't have a recommendation. I don't know. Maybe there are no issues, and I just thought I'd put it out there for the group to consider.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

One of the things, just in reading both the IFR and the NPRM, one of the things that's apparent is that there are cases where the EHR technology is required to have the capability of using particular standards whose use is not required in the NPRM. In other words, you have to have a capability using a particular standard, and you may have to perform that function in the NPRM, but not necessarily in the NPRM using the standard. I mean, in my own view, that general framework makes it easier for new adopters of EMRs. But I don't know if, back to your question on timing, if there is a timing issue that we want to introduce a discussion on or make a comment on about aligning those two at some point in the future so that the requirements of the NPRM actually align with the standards and the capabilities.

**Joyce Sensmeier – HIMSS – VP of Informatics**

I think that's a good point, and certainly want to emphasize the adoption, you know, the ease of adoption issue because there are many challenges, as we can see occurring. So I think that would add some clarity.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Let me bring up one particular issue that has come up in a couple of different fora that has to do with some of our recommendations and the way they appeared in the IFR, and that is on the administrative simplification side. The requirement in the IFR is to use basically the HIPAA adopted standards and CAQH CORE. And so the HIPAA adopted standards are 4010 and 5010 now, and then later on in a couple years only using X12 version 5010.

One of the issues that we might want to comment on is the fact that the CAQH CORE operating rules apply exclusively to the X12 4010 A1 version, and there is no CORE set of operating rules that exists yet, certainly not as public guidance, and not what's mentioned in the IFR for version 5010. And so, since according to the CMS regulation we're now in the 5010 implementation period, and trading partners can voluntarily and legally use 5010 today, the requirement to use the HIPAA standards and CAQH CORE poses a technical problem because CORE cannot be used with 5010. I would characterize that as one of the things I mentioned earlier as a technical correction comment.

**Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.**

This is Don, Jamie. Can you hear me?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Yes.

**Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.**

Excellent. I wanted to agree with the comment you're making and affirm that I think that is correct that the CAQH CORE's rules today, at least phase one rules, would only apply to 4010.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Right. Is this a comment that we want to recommend to the standards committee then? Any objection to that? Welcome, Don. I didn't hear you sign on.

**Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.**

I've been listening and, when you got into this conversation, I asked to be able to speak.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Got it. Okay. I will take silence as consensus for the rest of you. What other comments might we want to consider making in bringing up for discussion in the standards committee meeting coming up?

**Kevin Hutchinson – Prematics, Inc. – CEO**

I can't think of additional ones right now, Jamie.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Well, that's where I am. Wes, Don, Joyce?

**Wes Rishel – Gartner, Inc. – Vice President & Distinguished Analyst**

No. I'm afraid I didn't come with a list, so I was just going to attempt to look informed by talking.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

No. I mean, I have a mental list, and I'm taking notes here. Okay. Eric, Chris, anything from either of you?

**Eric Strom – DoD Military Health System – Program Management Support**

No, not here. Not from Eric.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Well then, in that case, Judy, I think we've completed the business of the workgroup for this call.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Great. We need to ask if anybody from the public though wishes to make a comment. Chris, can you--?

**Chris Weaver – Altarum**

Yes. I've got it, Judy.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you.

**Chris Weaver – Altarum**

If anybody is on the line and would like to make a public comment, please press star, one, on your telephone keypad now. If you're following along online, and you want to dial in, you should see the slide in front of you. The number is 877-705-2976, and once you get dialed in, press star, one. If you guys want to wrap up while we're waiting for folks to queue up?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay. Well, I think just in terms of wrapping up, so we've discussed here a series of different comments that we want to suggest to the standards committee. A lot of them really fit under the umbrella of requesting more specific guidance in terms of constraints, elimination of optionality, and just clarifications for many of the standards that are adopted.

We also had a couple of things that I would put into the category of technical corrections, and we have a work item, which is that I'm going to follow up with the chair of the HITSP public health population care committee to understand and to really inform us on any progress in terms of the immunization messaging standards that would align with the adopted standards in terms of HL-7 2.5.1. And I think that's my summary. Anything anybody wants to add to that?

**Kevin Hutchinson – Prematics, Inc. – CEO**

No. Thanks for leading us through the discussion, Jamie.

**Joyce Sensmeier – HIMSS – VP of Informatics**

Yes. That was good. Thank you.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Thank you. Are there any public comments?

**Chris Weaver – Altarum**

We have no public comment.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Great. Thank you, everybody.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Thank you.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Thanks, everyone, very much. Appreciate your time.

**Kevin Hutchinson – Prematics, Inc. – CEO**

Get a snow shovel.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

All right. Thank you.

**Kevin Hutchinson – Prematics, Inc. – CEO**

See you.